

State of New Jersey  
Department of Labor and Workforce Development  
Division of Workers' Compensation  
PO Box 381  
Trenton, New Jersey 08625-0381

**APPLICATION FOR REVIEW OR  
MODIFICATION OF FORMAL AWARD**

CASE No. \_\_\_\_\_

D.O. \_\_\_\_\_

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SOCIAL SECURITY NUMBER

NAME

ADDRESS (including County)

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NAME

ADDRESS (including County)

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☐ NEW JERSEY  
REGISTRATION NUMBER

☐ SSN

☐ FEDERAL EMPLOYER ID NUMBER

NAME

ADDRESS

TELEPHONE (Area Code)

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NAME (indicate if Not Covered or self-insured)

ADDRESS

CARRIER'S CLAIM FILE NUMBER

TO THE DIVISION OF WORKERS' COMPENSATION: (Applicant) \_\_\_\_\_

hereby makes application to the Division of Workers' Compensation to review the Order entered on \_\_\_\_\_, \_\_\_\_\_

by \_\_\_\_\_ and respectfully states: The following is an accurate, succinct  
description of the factual, medical, and legal reasons for the relief sought in the Application: (Use additional sheets if necessary)

As To  
Claim  
Petitioner

D.O.B

Sex

Date of Injury

Date of Last Compensation Paid

Present Employment Status

This is the \_\_\_\_\_ application for Review or Modification of this award.  
(Number)

In occupational disease claims, list claims against other employers filed or to be filed for the same or similar occupational diseases.

### DATES OF EMPLOYMENT

(Applicant)

Subscribed and sworn or affirmed  
to before me this                day of  
                        , 20

The Privacy Act, 5 U.S.C. § 552a, the Social Security Act, 42 U.S.C. § 405, and *N.J.S.A. 34:15-1 et seq.* authorize the Division of Workers' Compensation to request that the Petitioner supply the Division with his or her Social Security number for record keeping purposes and cross-matches with the Social Security Administration, Workforce New Jersey, Temporary Disability Insurance and any other proper public purpose.

## DIVISION OF WORKERS' COMPENSATION